Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEDME SERVICES CORPORATION

Respondent Name
LUMBERMENS UNDERWRITING ALLIANCE

MFDR Tracking Number
M4-11-2626-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This code is a payable code with the supplies that are warranted and necessary due to the purchase of the EMS unit on 07/31/2009. The lead wires become a hazard if not replaced regularly. In order to insure the patient's safety and full benefit from the use of the machine it is important that new lead wires by supplied. This is in accordance with the supplier manual Chapter 43.2."

Amount in Dispute: $221.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that is has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 5, 2010 Through July 7, 2010	HCPCS Code A4557NU Lead Wires	$55.40 X 4 = $221.60	$221.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B15-Procedure/Service is not paid separately.
   - 193-Original payment decision maintained.
   - Reimbursement for lead wires is dependent upon frequency of use of the stimulator. Documentation does not

support frequent payment of lead wires (Per DMERC policy).

- Eff 8/1/03, there will be no separate allowance for replacement electrodes (A4556), conductive paste (A4558), lead wires (A4557), replacement batteries (A4630) or a battery charges used w/a purchased TENS/NMS unit.

Issues

Is the requestor entitled to reimbursement for HCPCS codes A4557NU?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4557 based upon unbundling. On the disputed dates of service, the requestor billed HCPCS codes A4595, A4630, A4557, and A9150.

   Per 28 Texas Administrative Code §134.203(b)(1), the Division referred to CCI edits to determine if HCPCS code A4557 is a component of any other service billed on the disputed dates of service. The Division finds no CCI conflicts exist for billing HCPCS code A4557; therefore, reimbursement is recommended.

   Per 28 Texas Administrative Code §134.203(d) "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   The 2010 DMEPOS fee schedule finds that HCPCS code A4557 has a fee of $22.14; therefore, per 28 Texas Administrative Code §134.203(d), the MAR is $22.14 X 125% = $27.67. The requestor billed for two units per date of service; therefore, $27.67 multiplied by 2 is $55.34 multiplied by 4 dates = $221.36. The respondent paid $0.00. As a result, reimbursement of $221.36 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $221.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $221.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/13/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.